Cancer Council Victoria

Cancer Registration

Victorian Cancer Registry

Hospital Information Kit

VICTORIA State Government

Cancer Registration – Hospital Information Kit

All Victorian hospitals are required to notify the Victorian Cancer Registry (VCR) of patients with cancers reportable under the *Improving Cancer Outcomes Act 2014 (Vic).*

For the purpose of this document, the term *hospital* includes public and private hospitals, day procedure and day endoscopy centres. A hospital is considered a notifier of cancer to the VCR.

Cancer registrations are also referred to as cancer notifications.

The VCR is committed to providing support to all hospitals to enable accurate registration of reportable cancer diagnoses.

The intention of this document is to clearly outline the requirements for registration of cancer cases to the VCR. The document should be referenced by those who register cancer cases, in particular the Reporting Guide section for each data item. The document also contains technical information for software vendors who update the front end cancer registration screens and data extracts.

This document should be used in conjunction with our **Reportable Cancers – Guide to identification of cancers reportable to the Victorian Cancer Registry** which provides a comprehensive list of reportable cancers and outlines when a cancer registration is required.

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Introduction

The reporting of cancer to the Victorian Cancer Registry (VCR) by hospitals is mandated by the *Improving Cancer Outcomes Act 2014 (Vic)* and *Improving Cancer Outcomes (Diagnosis Reporting) Regulations 2015 (Vic)*. The specifications that are included in this document stipulate the individual data items that are mandated by this legislation and how to report the data.

Our companion document entitled **Reportable Cancers – Guide to identification of cancers reportable to the Victorian Cancer Registry** indicates which cancers are required to be reported to the VCR.

Reporting changes from year to year are attempted to be kept minimal for consistency in data collection and resource impacts for reporting organisations. Any reporting changes will be communicated to hospitals six months prior to the change. Implementation of any changes will be from 1 July unless otherwise indicated.

The data items required to be reported to the Victorian Cancer Registry from 1 July 2018 are listed below:

	Data Item		Data Item
1	Patient Surname	26	Date of Diagnosis of Primary Cancer
2	Patient First Given Name	27	Estimated Date Flag
3	Patient Second Given Name	28	Cancer Diagnosed Prior to Admission Flag
4	Previous/Maiden/Other Names	29	Where Previously Diagnosed
5	Date of Birth	30	Primary Site
6	Sex	31	Laterality of Primary Tumour
7	Medicare Number	32	Morphology
8	Individual Healthcare Identifier	33	Grade
9	Country of Birth	34	Investigations
10	Language Spoken at Home	35	ECOG Performance Status
11	Indigenous Status	36	Metastatic Site
12	Building/Property Name	37	Additional Information
13	Street Address	38	Stage
14	Suburb	39	Staging System
15	Postcode	40	TNM Stage – T code
16	Treating Doctor Surname	41	TNM Stage – N code
17	Treating Doctor First Given Name	42	TNM Stage – M code
18	Treating Doctor Second Given Name	43	General Practitioner Surname
19	Treating Doctor Address	44	General Practitioner First Given Name
20	Treating Doctor Medicare Provider Number	45	General Practitioner Second Given Name
21	Hospital Name	46	General Practitioner Address
22	Hospital Campus Code	47	General Practitioner Medicare Provider Number
23	Unit Record Number	48	Name of Person Completing the Registration
24	Date of Admission	49	Date of Registration
25	Date of Discharge		

1 Registration of cancer

Registration of reportable cancer cases is via the secure **VCR Internet Portal (VCRIP)**

https://registry.cancervic.org.au

Access to VCRIP is restricted to registered users only.

Before commencing submission of cancer registrations, the user must apply for a VCRIP account.

1.1 How to apply for a VCRIP account

If you require a VCRIP account, please send an email with the following information:

Hospital details

- Name of hospital
- Address
- Campus code, if known

User details

- First name
- Surname
- Position
- Department
- Phone number
- Email address

Email your request to **vcr@cancervic.org.au**

If you plan to use our online e-form to register a cancer, you can commence as soon as your account has been created. We will notify you by email when your account is ready.

For hospitals wanting to use upload files, initial submission of a test file is required. This testing can be co-ordinated with the VCR Electronic Notifications Coordinator. Testing is also required when the standard file format is updated.

1.2 Contact details

For further information or enquiries regarding VCRIP and registration of cancer, please contact

VCR Electronic Notifications Coordinator

Phone (03) 9514 6236

Email **vcr@cancervic.org.au**

1.3 What cancers are reportable?

We have provided a guide indicating the reportable cancers: *Reportable Cancers – Guide to identification of cancers reportable to the Victorian Cancer Registry.* This document includes ICD-10-AM codes that can be used to identify cases that should be reported to the VCR (*Table 2*).

1.3.1 Hospital management of reportable cancers

Some of the data items required by VCR are routinely collected by hospitals in their patient administration systems. In these cases, consistency with the definitions and data standards outlined in the National Health Data Dictionary is retained. It should be noted however, that the cancer registration also requires additional data items.

Hospitals will require some means of identifying the reportable cancers (some systems enable the reportable cancer ICD10-AM site codes to be flagged so a cancer registration is triggered when the code is entered at time of coding) and will also need to keep track of the cases registered with VCR.

For those hospitals where cancer registration is maintained by the cancer registration module of their patient administration system, these functionalities mentioned above should be available and utilised.

If a hospital has multiple campus sites that are using the one patient administration system and a single medical record i.e. paper or scanned (one unit record number system), then a separate registration is not required from each campus unless there is a change in the disease status.

1.4 References

References	Useful Links
Health Data Standards Systems (HDDS) reference files, Department of Health and Human Services (DHHS)	https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files
International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) current version	Relevant ICD-10-AM cancer codes are listed in Table 2 of Reportable Cancers – Guide to identification of cancers reportable to the Victorian Cancer Registry https://registry.cancervic.org.au
National Health Data Dictionary (NHDD), Australian Institute of Health and Welfare (AIHW), Metadata Online Registry (METeOR)	http://meteor.aihw.gov.au
Reportable Cancers – Guide to identification of cancers reportable to the Victorian Cancer Registry	https://registry.cancervic.org.au

2 Data submission

There are two methods available for submitting cancer registrations via VCRIP:

1. E-form
2. Data upload file

2.1 Data submission by e-form

The online e-form allows registered users to logon to VCRIP to complete and submit individual cancer registrations.

This method is suitable for smaller hospitals that do not have large numbers of reportable cancer cases.

Refer to the E-form screenshot in Appendix 1.

To access the e-form, logon to VCRIP.

On the left hand side of the Notifiers home page, select

Submit data by e-form

2.2 Data submission by upload file

This method is for hospitals that are able to register and extract cancer cases from their patient administration system in the VCR standard file format (refer to Section 3).

To upload a cancer extract file, logon to VCRIP.

On the left hand side of the Notifiers home page, select

Submit data by file

The following section outlines the standard file format and data specifications for reporting cancer cases by hospital extract file.

3 File format

The current standard file format for hospitals for the reporting of cancer cases is ASCII text file.

From 1 July 2018, the preferred standard file format will be XML.

It is expected that hospitals will transition to XML within two years.

Refer to Appendix 2 for XML File Specifications. The associated XML tag for each data item is also included in the Data Specifications in Section 5.

3.1 ASCII text file format rules

Each cancer registration record in the ASCII text file must adhere to the following rules:

- Each line is prefixed by a specified four-digit field identifier (or line number) to identify the type of information supplied on that line.
- Only one type of information is supplied per line.
- An optional tab character may follow the four-digit line number preceding the variable length data.
- The maximum length for each line of text (excluding the line number) must not exceed 75 characters.
- Multiple lines are allowed only for the free text field 1373 Additional Information. Where data exceeds 75 characters for this field, begin a new line. Each new line should be prefixed with the line number 1373 and tab character as appropriate.
- If there is no information available on your system for a particular field, it is still preferable to include the associated field line number even though the line will be blank.
- Sequencing of fields in the cancer registration record is by line number in ascending order.
- Each cancer registration record must begin with line number 1000 to denote the start of the record.
- Each cancer registration record must terminate with line number 2999 to denote the end of the record.

Refer to the sample hospital cancer registration extract record (ASCII text) in Appendix 3.

4 Field summary and changes

This section provides a summary of the fields in the cancer registration record and changes since the previous specifications.

ASCII Field/ Line No.	Data Item Name	Changes since 2015 specifications
1000	*{Start of record}*	
1010	Patient Surname	Updated data item name
1020	Patient First Given Name	Updated data item name
1030	Patient Second Given Name	Updated data item name
1040	Date of Birth	
1050	Sex	Updated code set
1055	Medicare Number	
1056	Individual Healthcare Identifier	Updated data item name
1060	Previous/Maiden/Other Names	Updated data item name
1070	Indigenous Status	
1100	Building/Property Name	
1110	Street Address	
1120	Suburb	
1130	Postcode	
1140	Country of Birth	
1150	Language Spoken at Home	
1210	Treating Doctor Surname	
1215	Treating Doctor First Given Name	
1216	Treating Doctor Second Given Name	
1220	Treating Doctor Address	
1225	Treating Doctor Medicare Provider Number	
1230	Hospital Name	Updated data item name
1235	Hospital Campus Code	
1240	Unit Record Number	
1260	Date of Admission	Updated data item name
1270	Date of Diagnosis of Primary Cancer	Updated data item name
1271	Estimated Date Flag	

(*continued*)

(*Field summary and changes continued*)

ASCII Field/ Line No.	Data Item Name	Changes since 2015 specifications
1280	Cancer Diagnosed Prior to Admission Flag	Updated data item name
1285	Where Previously Diagnosed	Updated data item name
1290	Date of Discharge	
1320	Primary Site	Updated data item name
1325	Laterality of Primary Tumour	
1330	Primary Site Text Description	Removed. Not required from July 2018
1335	Evidence of Metastatic Disease	Removed. Not required from July 2018
1340	Metastatic Site	Updated data item name
1345	Metastatic Site Text Description	Removed. Not required from July 2018
1360	Morphology	Updated data item name and decrease field
1365	Grade	Updated data item name and code descriptors
1370	Investigations	Updated data item name
1371	Other Basis of Diagnosis	Removed. Not required from July 2018
1372	ECOG Performance Status	Updated code set
1373	Additional Information	
1390	Stage of Cancer Flag	Removed. Not required from July 2018
1391	Stage	Updated data item name and code set
1392	Staging System	
1393	**TNM Stage – T code**	**New. Report from July 2018**
1394	**TNM Stage – N code**	**New. Report from July 2018**
1395	**TNM Stage – M code**	**New. Report from July 2018**
2210	General Practitioner Surname	
2215	General Practitioner First Given Name	
2216	General Practitioner Second Given Name	Updated data item name
2220	General Practitioner Address	
2225	General Practitioner Medicare Provider Number	
2900	Name of Person Completing the Registration	Updated data item name
2910	Date of Registration	Updated data item name
2999	*{End of record}*	

5 Data specifications

This section lists the prescribed data items and provides the definitions, data types, maximum field size, code sets, reporting guides and other information for each item.

Note: The default value for all data entry fields is NULL unless otherwise specified.

There are 49 prescribed data items. Information about each data item is presented in the following structured format:

Data Item Name

Definition	A statement that expresses the essential nature of a data item and its differentiation from all other data items.
Purpose	The main reason(s) for collection of this data item.
Reporting Obligation	Indicates whether the data item is: – **Mandatory** (must be reported for all cases, no blanks permitted) or – **Mandatory if available/applicable** (must be reported if data is available or applicable, otherwise leave blank). Some data items may not always apply, for example Metastatic Site.
ASCII Field/Line No.	The 4-digit field identifier (or line number) associated with this data item for ASCII text file extracts.
Data Type	The type of data expected in this field. There are four different data types: **Alphabetic** = only letters (upper and lower case A–Z) **Numeric** = only numbers (0–9) **String** = a string of characters which may contain letters, numbers, and punctuation characters such as apostrophe, hyphen and space. **Date** = a valid date in the specified format (DDMMYYYY)
Format	The expected format or layout of the data item. **A** = any alphabetic character **N** = any numeric character **X** = any string character **DDMMYYYY** = standard date format, DD=day, MM=Month, YYYY=Year, e.g. 30062018 Other format examples: NNNN denotes a 4-digit number (e.g. Postcode 3000) N(11) denotes a number containing 11 digits (e.g. Medicare Number) X(30) denotes a string with maximum character limit of 30 (e.g. Patient Surname)
Field Size	The required or maximum length of characters for this data item.

(*continued*)

(*Data Specifications continued*)

Code Set	The set of permissible values for this data item as specified.
Validations	Any constraints or restrictions that apply to this data item.
Missing Data	Indicates whether missing data is acceptable or not for this item.
Related Items	Other data items related to this data item.
Definition Source	Identifies the authority that defined this data item e.g. NHDD For METeOR sources, the unique numeric identifier of the related METeOR data item is included in brackets e.g. METeOR (613331)
Code Set Source	Identifies the authority that developed the code set (if any) for this data item.
XML Tag	XML label associated with this data item (for XML extracts).
Reporting Guide	Additional comments or advice on reporting the data item.

The specifications and reporting guide for each data item are listed in the following pages.

Patient Surname

Definition	The name a person has in common with some other members of their family.
Purpose	Identifies the patient uniquely when combined with other demographic data items.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1010
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Nil
Validations	The first character must be alphabetic.
Missing Data	Not acceptable
Related Items	Patient First Given Name, Patient Second Given Name, Previous/Maiden/Other Names
Definition Source	METeOR (613331)
Code Set Source	Not applicable
XML Tag	PatSurname
Reporting Guide	Report the surname of the patient.

Patient First Given Name

Definition	The person's identifying name(s) within the family group or by which the person is socially identified.
Purpose	Identifies the patient uniquely when combined with other demographic data items.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1020
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Not applicable
Validations	The first character must be alphabetic.
Missing Data	Not acceptable
Related Items	Patient Surname, Patient Second Given Name, Previous/Maiden/Other Names
Definition Source	METeOR (613340)
Code Set Source	Not applicable
XML Tag	PatFirstName
Reporting Guide	Report the first given name of the patient.

Patient Second Given Name

Definition	The person's identifying name(s) within the family group or by which the person is socially identified.
Purpose	Identifies the patient uniquely when combined with other demographic data items.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1030
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Not applicable
Validations	The first character must be alphabetic. Multiple names must be separated by a space.
Missing Data	Acceptable
Related Items	Patient Surname, Patient First Given Name, Previous/Maiden/Other Names
Definition Source	METeOR (613340)
Code Set Source	Not applicable
XML Tag	PatSecondName
Reporting Guide	Report the second given name(s) of the patient if available.

Date of Birth

Definition	The day, month and year of birth of the person.
Purpose	Identifies the patient uniquely when combined with other demographic data items.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1040
Data Type	Date
Format	DDMMYYYY
Field Size	8
Code Set	Valid date
Validations	Date of Birth must be on or before Date of Admission. Year (YYYY) can only be 19xx or 20xx.
Missing Data	Not acceptable
Related Items	Nil
Definition Source	METeOR (375191)
Code Set Source	Not applicable
XML Tag	DOB
Reporting Guide	Report the patient's date of birth.

Sex

Definition	The distinction between male, female and others who do not have biological characteristics typically associated with either the male or female sex.	
Purpose	Identifies the patient uniquely when combined with other demographic data items.	
Reporting Obligation	Mandatory	
ASCII Field/Line No.	1050	
Data Type	Numeric	
Format	N	
Field Size	1	
Code Set	**Code**	**Descriptor**
	1	Male
	2	Female
	3	Indeterminate
	4	Other
Validations	Valid code as per code set	
Missing Data	Not acceptable	
Related Items	Nil	
Definition Source	METeOR (635126)	
Code Set Source	NHDD (DHHS modified)	
XML Tag	Sex	

(*continued*)

(Sex continued)

Reporting Guide	A person's sex is usually described as either being male or female. Sex is assigned at birth and is relatively fixed. **Indeterminate** should be used for infants with ambiguous genitalia, where the biological sex, even following genetic testing, cannot be determined. This code should not generally be used on data collection forms completed by the respondent. Note: **Indeterminate** can only be assigned for infants aged less than 90 days. **Other** includes: An intersex person, who because of a genetic condition was born with reproductive organs or sex chromosomes that are not exclusively male or female and who identifies as being neither male nor female A non-intersex person who identifies as neither male nor female Excludes: Transgender, transsexual and chromosomally indeterminate individuals who identify with a particular sex (male or female).

Medicare Number

Definition	Person identifier, as allocated by the Health Insurance Commission to eligible persons under the Medicare scheme, that appears on a Medicare card.
Purpose	Identifies the patient uniquely when combined with other demographic data items.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1055
Data Type	Numeric
Format	N(11)
Field Size	11
Code Set	The patient's Medicare number and individual reference number as issued by Medicare Australia
Validations	Valid code as per code set
Missing Data	Acceptable
Related Items	Nil
Definition Source	METeOR (270101)
Code Set Source	Medicare Australia
XML Tag	MedicareNo
Reporting Guide	Report the patient's full Medicare number including the individual reference number (number against patient name).

Individual Healthcare Identifier

Definition	The numerical identifier that uniquely identifies each individual in the Australian healthcare system.
Purpose	To uniquely identify individuals in the healthcare system.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1056
Data Type	Numeric
Format	N(16)
Field Size	16
Code Set	Not applicable
Validations	Nil
Missing Data	Acceptable
Related Items	Nil
Definition Source	METeOR (432495)
Code Set Source	Not applicable
XML Tag	IHI
Reporting Guide	Report the patient's Individual Healthcare Identifier.

Previous/Maiden/Other Names

Definition	Any previous surnames, maiden name, or any other names the patient may be known by.
Purpose	Previous or other names of the patient assist with data linkage.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1060
Data Type	String
Format	X(50)
Field Size	Maximum 50
Code Set	Not applicable
Validations	The first character must be alphabetic. Multiple names must be separated by a space.
Missing Data	Acceptable
Related Items	Patient Surname, Patient First Given Name, Patient Second Given Name
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	PatOtherName

Reporting Guide	Report any previous, maiden or other surnames or given names the patient may be known by.

Indigenous Status

Definition	An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives.	
Purpose	To enable planning, service delivery, and monitoring of indigenous health at a state and national level.	
Reporting Obligation	Mandatory	
ASCII Field/Line No.	1070	
Data Type	Numeric	
Format	N	
Field Size	1	
Code Set	**Code**	**Descriptor**
	1	Aboriginal but not Torres Strait Islander origin
	2	Torres Strait Islander but not Aboriginal origin
	3	Both Aboriginal and Torres Strait Islander origin
	4	Neither Aboriginal nor Torres Strait Islander origin
	8	Question unable to be asked
	9	Patient refused to answer
Validations	Valid code as per code set	
Missing Data	Not acceptable	
Related Items	Nil	
Definition Source	NHDD	
Code Set Source	NHDD (DHHS modified)	
XML Tag	IndigStatus	
Reporting Guide	Report the relevant indigenous status of the patient.	

Building/Property Name

Definition	The full name used to identify the physical building, address site or property where the patient usually resides.
Purpose	Collected for administrative purposes, individual identification, and identification of the regions where the first incidence of cancer was reported. Used in conjunction with other address components (i.e. street address, suburb, postcode and Australian state/territory), forms a complete geographical/physical address of a person.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1100
Data Type	String
Format	X(50)
Field Size	Maximum 50
Code Set	Not applicable
Validations	Nil
Missing Data	Acceptable
Related Items	Street Address, Suburb, Postcode
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	PropertyName
Reporting Guide	Report the building or property name. For example: Bayside Caravan Park (site name of caravan park) Chatswood House Aged Care (site name of aged care home) Pinewood Lodge Nursing Home (site name of nursing home) Yallambee Village Retirement Village (site name of gated property) Blue Hills Farm (name of the property)

Street Address

Definition	The usual residential street address where a person lives under normal circumstances.
Purpose	Collected for administrative purposes, individual identification, and identification of the regions where the first incidence of cancer was reported.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1110
Data Type	String
Format	X(50)
Field Size	Maximum 50
Code Set	Not applicable
Validations	Nil
Missing Data	Not acceptable
Related Items	Building/Property Name, Suburb, Postcode
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	StreetAddr

Reporting Guide	Report the street number, name, and type of the patient's usual residential address e.g. 18 Lincoln St. Use acceptable Australia Post abbreviations. Apartment, flats or units are to be recorded as 15/18 Lincoln St. Post Office (PO) boxes and Road Side Delivery (RSD) should only be provided when no other residential address is available.

Suburb

Definition	The usual residential suburb/locality where a person lives under normal circumstances.
Purpose	Collected for administrative purposes, individual identification, and identification of the regions where the first incidence of cancer was reported.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1120
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Postcode/Locality reference file for HDSS collections, available from: https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files
Validations	The first character must be alphabetic.
Missing Data	Not acceptable
Related Items	Building/Property Name, Street Address, Postcode
Definition Source	VCR
Code Set Source	Australia Post (DHHS modified)
XML Tag	Suburb
Reporting Guide	Report the suburb of the patient's usual residential address.

Postcode

Definition	The Australian numeric descriptor for a postal delivery area for an address.
Purpose	Collected for administrative purposes, individual identification, and identification of the regions where the first incidence of cancer was reported.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1130
Data Type	Numeric
Format	NNNN
Field Size	4
Code Set	Postcode/Locality reference file for HDSS collections, available from: https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files
Validations	Valid code as per code set
Missing Data	Not acceptable
Related Items	Suburb, Street Address, Building/Property Name
Definition Source	METeOR (611398)
Code Set Source	Australia Post (DHHS modified)
XML Tag	Postcode
Reporting Guide	Report the usual residential postcode of the patient.

Country of Birth

Definition	The country in which the person was born, as represented by a code.
Purpose	To facilitate epidemiological studies.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1140
Data Type	Numeric
Format	NNNN
Field Size	4
Code Set	Country of Birth and Country of Residence Standard Australian Classification of Countries (SACC) for HDSS collections, available from: https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files
Validations	Valid code as per code set
Missing Data	Not acceptable
Related Items	Nil
Definition Source	METeOR (659454)
Code Set Source	Australian Bureau of Statistics – Standard Australian Classification of Countries (SACC), 2016 (DHHS modified)
XML Tag	COB
Reporting Guide	Report the country in which the patient was born, not the country of residence. For patients born in Australia, report code 1101. If the patient's country of birth is not stated, report code 0003.

Language Spoken At Home

Definition	The language reported by a person as the main language other than English spoken by that person in his/her home (or most recent private residential setting occupied by the person) to communicate with other residents of the home or setting and regular visitors.
Purpose	To facilitate epidemiological studies and ensure cancer control initiatives are communicated adequately to all Victorian communities.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1150
Data Type	Numeric
Format	NNNN
Field Size	4
Code Set	Preferred Language Australian Standard Classification of Languages (ASCL) for HDSS collections, available from: https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files
Validations	Valid code as per code set
Missing Data	Not acceptable
Related Items	Nil
Definition Source	METeOR (460125)
Code Set Source	Australian Bureau of Statistics – Australian Standard Classification of Languages (ASCL), 2016 version (DHHS modified)
XML Tag	Language
Reporting Guide	This may be a language other than English even where the person can speak fluent English. English – report code 1201. Not Stated – report code 0002.

Treating Doctor Surname

Definition	The surname of the patient's treating doctor.
Purpose	Collected for administrative purposes.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1210
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Not applicable
Validations	The first character must be alphabetic. Can be auto-extracted from the patient administration system.
Missing Data	Not acceptable
Related Items	Treating Doctor First Given Name, Treating Doctor Second Given Name, Treating Doctor Address, Treating Doctor Medicare Provider Number
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	TDSurname

Reporting Guide	Report the treating doctor's surname. The treating doctor is the doctor in charge of the case, responsible for the patient's treatment or care during their admission. Often this is recorded in the hospital patient administration system as the Head of Unit. Do NOT report the name of a registrar or resident.

Treating Doctor First Given Name

Definition	The first given name of the patient's treating doctor.
Purpose	Collected for administrative purposes.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1215
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Not applicable
Validations	The first character must be alphabetic. Can be auto-extracted from the patient administration system.
Missing Data	Not acceptable
Related Items	Treating Doctor Surname, Treating Doctor Second Given Name, Treating Doctor Address, Treating Doctor Medicare Provider Number
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	TDFirstName
Reporting Guide	Report the first given name of the treating doctor.

Treating Doctor Second Given Name

Definition	The second given name of the patient's treating doctor.
Purpose	Collected for administrative purposes.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1216
Data Type	String
Format	X(20)
Field Size	Maximum 20
Code Set	Not applicable
Validations	The first character must be alphabetic. Can be auto-extracted from the patient administration system.
Missing Data	Acceptable
Related Items	Treating Doctor Surname, Treating Doctor First Given Name, Treating Doctor Address, Treating Doctor Medicare Provider Number
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	TDSecondName
Reporting Guide	Report the second given name of the treating doctor.

Treating Doctor Address

Definition	The business address of the patient's treating doctor.
Purpose	Collected for administrative purposes.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1220
Data Type	String
Format	X(75)
Field Size	Maximum 75
Code Set	Not applicable
Validations	Can be auto-extracted from the patient administration system.
Missing Data	Acceptable
Related Items	Treating Doctor Surname, Treating Doctor First Given Name, Treating Doctor Second Given Name, Treating Doctor Medicare Provider Number
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	TDAddress
Reporting Guide	Report the street number, street name, suburb and postcode separated by spaces.

Treating Doctor Medicare Provider Number

Definition	The Medicare Provider Number is the provider number as issued by Medicare which uniquely identifies the treating doctor and the location from which the service is delivered.
Purpose	Collected for administrative purposes.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1225
Data Type	String
Format	X(8)
Field Size	8
Code Set	Not applicable
Validations	Nil
Missing Data	Acceptable
Related Items	Treating Doctor Surname, Treating Doctor First Given Name, Treating Doctor Second Given Name, Treating Doctor Address.
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	TDMediProvidNo
Reporting Guide	Report the treating doctor's Medicare Provider Number if known.

Hospital Name

Definition	The name of the reporting hospital or hospital campus.
Purpose	To identify the hospital making the report.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1230
Data Type	String
Format	X(50)
Field Size	Maximum 50
Code Set	Hospital Campus Code reference table for HDSS collections, available from: https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files
Validations	Valid name as per code set
Missing Data	Not acceptable
Related Items	Hospital Campus Code
Definition Source	VCR
Code Set Source	DHHS
XML Tag	HospitalName
Reporting Guide	Report the name of your hospital or hospital campus where the patient was treated.

Hospital Campus Code

Definition	Indicates the hospital campus where the episode of care was provided.
Purpose	To identify the hospital making the report.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1235
Data Type	Numeric
Format	NNNN
Field Size	4
Code Set	Hospital Campus Code reference table for HDSS collections, available from: https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files
Validations	Valid code as per code set
Missing Data	Not acceptable
Related Items	Hospital Name
Definition Source	DHHS
Code Set Source	DHHS
XML Tag	CampusCode
Reporting Guide	Report the hospital campus code as allocated by DHHS.

Unit Record Number

Definition	The unique patient identifier, hospital-generated by the hospital or campus.
Purpose	To uniquely identify the patient at that hospital and ensure all future registrations from the health service are linked to the same record.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1240
Data Type	String
Format	X(15)
Field Size	Maximum 15
Code Set	Not applicable
Validations	Nil
Missing Data	Not acceptable
Related Items	Nil
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	URN

Reporting Guide	Report the Unit Record Number of the patient at your hospital or campus. This can also be referred to as the patient's record number, medical record number or UR number.

Date of Admission

Definition	The date of the patient's attendance at your facility for this episode of care.
Purpose	Used with Date of Discharge to define an episode of care.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1260
Data Type	Date
Format	DDMMYYYY
Field Size	8
Code Set	Valid date
Validations	Date of Admission must be on or after Date of Birth. Date of Admission cannot be after Date of Registration.
Missing Data	Not acceptable
Related Items	Date of Discharge
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	AdmissionDate
Reporting Guide	Report the date the patient attended your facility for this episode of care.

Date of Diagnosis of Primary Cancer

Definition	The date when the cancer was first diagnosed. This may not necessarily be a date during the current episode.
Purpose	Collected for accurate identification of the diagnosis date of the cancer and population cancer statistics and research.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1270
Data Type	Date
Format	DDMMYYYY
Field Size	8
Code Set	Valid date
Validations	Do NOT default this field to the current date or any other date. If the primary cancer was diagnosed prior to admission, diagnosis date must be prior to admission date. If the primary cancer was NOT diagnosed prior to admission, diagnosis date must be on or after admission date but prior to date of discharge. Diagnosis date cannot be after registration date.
Missing Data	Not acceptable
Related Items	Estimated Date Flag
Definition Source	METeOR (416129), VCR modified
Code Set Source	Not applicable
XML Tag	DiagnosisDate

(*continued*)

Reporting Guide

Report the date of primary cancer diagnosis.

This information should be obtained from the patient's diagnostic pathology report, imaging result, exploratory surgery, clinical diagnosis or a date within a letter or referral, multi-disciplinary team meeting notes or correspondence from another institution or hospital.

If the **exact date is not known**, do not default to the current date. Instead, record the best estimate based on whatever information is available.

For example:

If only month and year is known, report the date as **01**/MM/YYYY

If only the year is known, report the date as **01/01/**YYYY

If a specified number of months ago (e.g. 6 months ago), record your best estimate

If this **date is unavailable**, or if no pathological test was done, then the date may be determined from one of the sources listed in the following sequence:

1. Date of the consultation at, or admission to the hospital, clinic or institution when the cancer was first diagnosed. DO NOT use the admission date of the current admission if the patient had a prior diagnosis of this cancer.
2. Date of first diagnosis as stated by a recognised medical practitioner or dentist.
3. Date the patient states they were first diagnosed with cancer. Note: this may be the only date available in a few cases (e.g. patient was first diagnosed in a foreign country).

For any of the three scenarios listed above, flag or tick Estimated Date field.

Unknown Primary

If the primary site is unknown and metastases have been diagnosed during this episode, report the date of the newly diagnosed metastatic disease.

Estimated Date Flag

Definition	Flag to indicate if date of diagnosis is an estimated date.	
Purpose	To indicate that Date of Diagnosis of Primary Cancer is estimated.	
Reporting Obligation	Mandatory	
ASCII Field/Line No.	1271	
Data Type	Numeric	
Format	N	
Field Size	1	
Code Set	**Code**	**Descriptor**
	0	Date of diagnosis is not estimated
	1	Date of diagnosis is estimated
Validations	Valid code as per code set	
Missing Data	Not acceptable	
Related Items	Date of Diagnosis of Primary Cancer	
Definition Source	VCR	
Code Set Source	VCR	
XML Tag	EstDateFlag	

Reporting Guide	Report the relevant code.

Cancer Diagnosed Prior to Admission Flag

Definition	Indicator as to whether the cancer has been previously diagnosed.	
Purpose	To indicate that further information is provided in Where Previously Diagnosed.	
Reporting Obligation	Mandatory	
ASCII Field/Line No.	1280	
Data Type	Alphabetic	
Format	A	
Field Size	1	
Code Set	**Code**	**Descriptor**
	Y	Yes
	N	No
	U	Unknown
Validations	Valid code as per code set	
Missing Data	Not acceptable	
Related Items	Where Previously Diagnosed	
Definition Source	VCR	
Code Set Source	VCR	
XML Tag	PriorDiagFlag	
Reporting Guide	Report the relevant code.	

Where Previously Diagnosed

Definition	Information regarding where cancer diagnosis was made if made prior to this episode.
Purpose	Collected to determine history of cancer.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1285
Data Type	String
Format	X(75)
Field Size	Maximum 75
Code Set	Not applicable
Validations	Required if Cancer Diagnosed Prior to Admission Flag is 'Y'
Missing Data	Acceptable if Cancer Diagnosed Prior to Admission Flag is 'N' or 'U'
Related Items	Cancer Diagnosed Prior to Admission Flag
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	WhereDiagnosed

Reporting Guide

Report where previously diagnosed in free text if known.

If you know that the patient was diagnosed at a particular hospital previously, please name this hospital.

If the cancer was diagnosed prior to consultation with your facility, but not at another hospital, please provide any information you may have.

For example:

- previous pathology laboratory used and biopsy number if available
- diagnostic imaging centre name
- state/territory of diagnosis if other than Victoria
- overseas or country name

If the patient was diagnosed interstate or overseas, it is important that you inform us of this information to enable us to exclude these cases from our Victorian incidence statistics.

Date of Discharge

Definition	The most recent date of discharge or separation from your facility.
Purpose	Used with Date of Admission to define an episode of care.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1290
Data Type	Date
Format	DDMMYYYY
Field Size	8
Code Set	Valid date
Validations	Discharge date cannot be before admission date.
Missing Data	Not acceptable
Related Items	Date of Admission
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	DischargeDate

Reporting Guide	Report the most recent date of discharge or separation from your facility.

Primary Site

Definition	The primary site is the site of origin of the tumour, as opposed to the secondary or metastatic sites, as represented by an ICD-10-AM code.
Purpose	Collected to classify tumours into clinically-relevant groupings on the basis of both their site and histological type. It is used for cancer surveillance and monitoring, cancer statistics and epidemiological studies.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1320
Data Type	String
Format	X(5)
Field Size	Maximum 5
Code Set	ICD-10-AM Chapter 2: Neoplasms – Primary Site Codes
Validations	One of the ICD-10-AM primary site codes in the range listed in Table 2 of the Reportable Cancers guide. Do NOT include metastatic site codes (C77-C79). First character must be 'C' or 'D'. Do not include punctuation within the code (i.e. omit dot). For example, report C509 instead of C50.9 C9291 instead of C92.91
Missing Data	Not acceptable
Related Items	Laterality of Primary Tumour, Morphology, Additional Information
Definition Source	VCR
Code Set Source	ICD-10-AM
XML Tag	PrimarySite

Reporting Guide	Only one primary site can be reported per registration. For multiple primaries, a separate registration is required for each primary site. For example, multiple tumours of the large intestine identified on a pathology report, such as an invasive mucinous adenocarcinoma of the caecum (M8480/3) and an invasive adenocarcinoma of the sigmoid colon (M8140/3). This would require two cancer registrations. Refer also to Reportable Cancers, Appendix 5, Table A for further examples. Please provide specific body site for Malignant Melanoma (C43) and Melanoma In Situ (D03) in the Additional Information field. Do NOT report metastatic site codes in this field.

Laterality of Primary Tumour

Definition	The side of a paired organ that is the origin of the primary cancer in a person with cancer.
Purpose	Collected to determine exact location and history of tumour.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1325
Data Type	Numeric
Format	N
Field Size	1

Code Set

Code	Descriptor
1	Right
2	Left
4	Bilateral
8	Not applicable
9	Unknown

Validations	Valid code as per code set
Missing Data	Not acceptable
Related Items	Primary Site, Morphology
Definition Source	METeOR (422769)
Code Set Source	VCR
XML Tag	Laterality

Reporting Guide

Report laterality for relevant paired body organs.

A paired organ is one in which there are two separate organs of the same kind, one on either side of the body e.g. breast, kidney, ureter, ovary, fallopian tube, middle ear, parotid gland, various sinuses, testis, nasal cavity, glottis (vocal cord), supraglottis and lung.

Each side of a paired organ is considered separate and described as lateral.

For other body sites that are not a paired organ select ‘Not applicable’.

Metastatic Site

Definition	The metastatic site is the anatomical position (topography) of the secondary cancer (can be localised or distant) which has spread from the primary tumour, as represented by an ICD-10-AM code.
Purpose	To record the spread of cancer which is vital information required to stage a cancer.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1340
Data Type	String
Format	X(75)
Field Size	Maximum 75
Code Set	ICD-10-AM metastatic site code in the range C77–C79 as listed in Table 2, Reportable Cancers.
Validations	One or more valid codes as per code set. First character of each code must be 'C'. Do not include punctuation within the code (i.e. omit dot). For example, report C770 instead of C77.0 C7988 instead of C79.88 Multiple codes must be separated by a space e.g. C770 C775 C788 C7988
Missing Data	Acceptable
Related Items	Morphology
Definition Source	VCR
Code Set Source	ICD-10-AM
XML Tag	MetSite

Reporting Guide	Report all applicable metastatic site codes. Use ICD-10-AM codes in the range C77–C79 only. Refer to Table 2 of Reportable Cancers guide. If a patient with a previously registered primary tumour now presents with metastatic disease, a new cancer registration is required. The new registration must contain the original primary tumour details plus the new metastatic site code(s).

Morphology

Definition	The histological classification of the cancer tissue (histopathological type) in a person with cancer, and a description of the course of development that a tumour is likely to take: benign or malignant (behaviour), as represented by a code.
Purpose	Collected to classify tumours into clinically-relevant groupings on the basis of both their morphology and degree of invasion or malignancy. It is also used for monitoring numbers of new cases of cancer and for cancer statistics and epidemiological studies.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1360
Data Type	Numeric
Format	N(5)
Field Size	5
Code Set	ICD-10-AM
Validations	Valid code as per code set. Do not report the M prefix or forward slash, for example, report 81403 instead of M8140/3
Missing Data	Not acceptable
Related Items	Primary Site, Metastatic Site
Definition Source	METeOR (399491)
Code Set Source	ICD-10-AM
XML Tag	Morph

Reporting Guide	Report the morphology code including the behaviour of the primary tumour.

Grade

Definition	The histopathological grade or differentiation in a person with cancer. Grading/differentiation describes how little the tumour resembles the normal tissue from which it arose.	
Purpose	To record the grade or severity of the primary tumour.	
Reporting Obligation	Mandatory	
ASCII Field/Line No.	1365	
Data Type	Numeric	
Format	N	
Field Size	1	
Code Set	**Code**	**Descriptor**
	1	Grade 1: Low grade; well differentiated, differentiated, NOS
	2	Grade 2: Intermediate grade; moderately differentiated, moderately well differentiated, intermediate differentiation
	3	Grade 3: High grade, poorly differentiated
	4	Grade 4: Undifferentiated, anaplastic
	9	Grade or differentiation not determined, not stated or not applicable
Validations	Valid code as per code set	
Missing Data	Not acceptable	
Related Items	Nil	
Definition Source	METeOR (422555)	
Code Set Source	METeOR	
XML Tag	Grade	

Reporting Guide	Report the relevant code to describe the grade/differentiation of the primary tumour. The tumour grade can be determined by pathological examination such as histology or cytology so these report results can be referenced. When more than one grade is documented for the primary tumour within the same specimen report, use the highest grade. For example, if grade 2–3 is documented, record the grade as 3.

Investigations

Definition	All investigations relevant to the diagnosis of this cancer both at your facility and elsewhere.	
Purpose	To derive the best basis of diagnosis.	
Reporting Obligation	Mandatory	
ASCII Field/Line No.	1370	
Data Type	String	
Format	X(15)	
Field Size	Maximum 15	
Code Set	**Code**	**Descriptor**
	8	Histology of primary tumour
	7	Histology of metastatic tumour
	6	Cytology/Haematology
	5	Exploratory surgery
	4	Endoscopy
	3	Imaging (including CT scan)
	2	Biochemistry/Immunology
	1	Clinical only
	9	Other/Unknown
Validations	Multi-selection field. One or more valid codes permitted, separated by a space and in the order specified above.	
Missing Data	Not acceptable	
Related Items	Additional Information	
Definition Source	VCR	
Code Set Source	VCR	
XML Tag	Investigations	

(*continued*)

(*Investigations continued*)

Reporting Guide	Include all investigations relevant to the diagnosis of cancer both at your facility and elsewhere if known. This information should be obtained from the patient's medical record or multidisciplinary team meeting documentation. Select one or more applicable codes in the hierarchy order specified, i.e. 8 through 1, then 9. If 9 (Other) is selected, enter the details in Additional Information.

ECOG Performance Status

Definition	Eastern Cooperative Oncology Group (ECOG) score given at the time of diagnosis outlining the extent to which a person with cancer's disease affects their daily living abilities.	
Purpose	To measure the quality of life of adult cancer patients and monitor best practice treatment.	
Reporting Obligation	Mandatory	
ASCII Field/Line No.	1372	
Data Type	Numeric	
Format	N	
Field Size	1	
Code Set	**Code**	**Descriptor**
	0	Fully active, able to carry on all pre-disease performance without restriction
	1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
	2	Ambulatory and capable of all self-care but unable to carry out work activities. Up and about more than 50% of waking hours
	3	Capable of only limited self-care, confined to bed or chair more than 50% of waking hours
	4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair
	9	Unknown/Not stated/Not applicable
Validations	Valid code as per code set	
Missing Data	Not acceptable	
Related Items	Additional Information	
Definition Source	METeOR (412327)	
Code Set Source	METeOR (VCR modified)	
XML Tag	ECOG	

(*continued*)

(*ECOG Performance Status continued*)

Reporting Guide	Eastern Cooperative Oncology Group (ECOG) performance status recorded at diagnosis or prior to treatment. ECOG information can be sourced from multi-disciplinary team meeting notes, other clinical notes or correspondence section of the medical record. The ECOG performance status scale does not apply to paediatric oncology patients. The Lansky or Karnofsky performance status scales are used. Select Unknown/Not stated/Not applicable (9) and record status and scale in Additional Information.

Additional Information

Definition	Any additional or other information relating to the cancer diagnosis.
Purpose	To collect any relevant additional information not captured by other fields.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1373
Data Type	String
Format	X(225)
Field Size	Maximum 225
Code Set	Nil
Validations	Nil, free text field.
Missing Data	Acceptable
Related Items	Primary Site, Investigations, ECOG Performance Status, Stage, Staging System
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	AdditInfo

Reporting Guide

Report any additional information if known, such as:

- Gleason scores
- Size of tumour
- Precise location of melanoma
- Melanoma Clarke's level and thickness
- Recurrence details
- Neoadjuvant or adjuvant therapy given
- Performance status if not ECOG i.e. Lansky, Karnofsky
- Other stage or staging classification not listed in code set

Additional information can be sourced from the patient medical record (including clinical notes, correspondence, investigations and results sections) and multi-disciplinary team meeting notes.

Report additional information in free text.

Stage

Definition	The summary stage documented at the time of diagnosis or shortly thereafter before any treatment is initiated, as represented by a code, to indicate how far a cancer has spread from the point of origin. The higher the number the greater the extent of disease.
Purpose	To define the extent of cancer at diagnosis. Cancer stage is an important determinant of treatment and prognosis and is used to evaluate new treatments and analyse outcomes.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1391
Data Type	String
Format	XX
Field Size	Maximum 2

Code Set

Code	Descriptor
1	Stage 1
1A	Stage 1A
1B	Stage 1B
1C	Stage 1C
2	Stage 2
2A	Stage 2A
2B	Stage 2B
2C	Stage 2C
3	Stage 3
3A	Stage 3A
3B	Stage 3B
3C	Stage 3C
4	Stage 4
4A	Stage 4A
4B	Stage 4B
4C	Stage 4C
9	Not applicable/Not available/Unknown/Other

(*continued*)

(*Stage continued*)

Validations	Valid code as per code set. Enable predictive text to limit value domain.
Missing Data	Not acceptable
Related Items	TNM Stage – T code, TNM Stage – N code, TNM Stage – M code, Staging System, Additional Information
Definition Source	VCR
Code Set Source	VCR
XML Tag	Stage

Reporting Guide	Report the stage of cancer at the time of diagnosis. This information should be obtained from the patient's medical record or multidisciplinary team meeting documentation. It may be documented in Roman numerals in the medical record. If the exact date or time period of diagnosis is unknown, register the stage of cancer documented at or around the time of admission to your facility. If a previously diagnosed cancer and patient is now returning with newly diagnosed metastatic disease, select '9' (Not applicable/Not available/ Unknown/Other). Classifying the stage of cancer varies from staging system and cancer site. The Victorian Cancer Registry has used the most common stage values as listed in this code set for our data collection purposes. For other stage values, select '9' and report stage in Additional Information.

Staging System

Definition	The reference which describes in detail the methods of staging and the definitions for the classification system used in determining the extent of cancer.
Purpose	To provide context to the stage value.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1392
Data Type	Numeric
Format	NN
Field Size	2

(*continued*)

(*Staging System continued*)

Code Set	Code	Abbreviation	Descriptor
	01	UICC	TNM Classification of Malignant Tumours (UICC)
	02	Durie & Salmon	Durie & Salmon for multiple myeloma staging
	03	FAB	French-American-British (FAB) for leukaemia classification
	04	ACPS	Australian Clinico-Pathological Staging (ACPS) System for colorectal cancer
	05	FIGO	International Federation of Gynaecologists and Obstetricians (FIGO) for gynaecological cancers
	06	Dukes	Dukes/Modified Dukes for colorectal cancer
	07	Ann Arbor	Ann Arbor staging system for lymphomas
	08	Binet	Binet Staging Classification for chronic lymphocytic leukaemia
	09	Rai	Rai staging system for chronic lymphocytic leukaemia
	10	CML	Chronic Myeloid Leukaemia (CML) staging system
	11	ISS	International Staging System (ISS) for myeloma
	12	AJCC	American Joint Committee on Cancer (AJCC) Cancer Staging Manual
	96	Other	Other reference
	97	Not applicable	Not applicable
	99	Unknown/ Not stated	Unknown/Not stated/Inadequately described
Validations	A valid code as per code set. Enable predictive text to facilitate selection		
Missing Data	Not acceptable		
Related Items	Stage, TNM Stage-T value, TNM Stage-N value, TNM Stage-M value, Additional Information		
Definition Source	METeOR (393364)		

(*continued*)

(*Staging System continued*)

Code Set Source	METeOR (VCR modified)
XML Tag	StagingSystem

Reporting Guide	Record the cancer staging system documented alongside the stage of cancer. This information should be obtained from the patient's medical record or multidisciplinary team meeting documentation. If 'Other' is selected, record the staging system in 'Additional Information'.

TNM Stage – T code

Definition	The size and extent of the primary tumour in a person with cancer, as represented by a code.
Purpose	To define the extent of cancer at diagnosis.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1393
Data Type	String
Format	X(5)
Field Size	Maximum 5
Code Set	Not applicable
Validations	Nil
Missing Data	Acceptable
Related Items	TNM Stage – N code, TNM Stage – M code, Stage, Staging System
Definition Source	METeOR (403564)
Code Set Source	Not applicable
XML Tag	TNM-T

Reporting Guide	Record the size and extent of the primary tumour at the time of diagnosis of the cancer. Record the stage in Arabic numerals and the appropriate upper or lower case alphabetic character, omitting the prefix 'T'. For example, record stage T2a for lung cancer as '2a'. Record if the T stage value has a prefix of 'c' or 'p' to indicate that the stage is based on 'clinical' or 'pathological' findings. For example, record breast cancer T stage pT2b as 'p2b'. This information should be obtained from the patient's medical record or multidisciplinary team meeting documentation. The TNM system classifies and groups cancers primarily by the anatomical extent of the tumour. The stage is allocated according to the size and extent of the primary tumour, involvement of regional lymph nodes and the presence or absence of distant metastases. TNM staging applies to solid tumours excluding brain tumours.

TNM Stage – N code

Definition	The absence or presence and extent of regional lymph node metastasis in a person with cancer, as represented by a code.
Purpose	To define the extent of cancer at diagnosis.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1394
Data Type	String
Format	X(5)
Field Size	Maximum 5
Code Set	Not applicable
Validations	Nil
Missing Data	Acceptable
Related Items	TNM Stage – T code, TNM Stage – M code, Stage, Staging System
Definition Source	METeOR (403661)
Code Set Source	Not applicable
XML Tag	TNM-N

Reporting Guide	Record the absence or presence and extent of regional lymph node metastasis at the time of diagnosis of the cancer. Record the stage in Arabic numerals and the appropriate upper or lower case alphabetic character, omitting the prefix 'N'. For example, record stage N1b for malignant melanoma of the skin as '1b'. Record if the N stage value has a prefix of 'c' or 'p' to indicate that the stage is based on 'clinical' or 'pathological' findings. For example, record colorectal cancer N stage pN1 as 'p1'. This information should be obtained from the patient's medical record or multidisciplinary team meeting documentation.

TNM Stage – M code

Definition	The absence or presence of distant metastasis in a person with cancer, as represented by a code.
Purpose	To define the extent of cancer at diagnosis.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1395
Data Type	String
Format	X(5)
Field Size	Maximum 5
Code Set	Not applicable
Validations	Nil
Missing Data	Acceptable
Related Items	TNM Stage – T code, TNM Stage – N code, Stage, Staging System
Definition Source	METeOR (403720)
Code Set Source	Not applicable
XML Tag	TNM-M

Reporting Guide	Record the absence or presence of distant metastasis at the time of diagnosis of the cancer. Record the stage in Arabic numerals omitting the prefix 'M'. For example, record stage 'M1b' for prostate carcinoma with bone metastases as '1b'. This information should be obtained from the patient's medical record or multidisciplinary team meeting documentation.

General Practitioner Surname

Definition	The surname of the patient's general practitioner/local doctor/local medical officer.
Purpose	Collected for administrative purposes.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	2210
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Not applicable
Validations	The first character must be alphabetic. Can be auto-extracted from the patient administration system.
Missing Data	Acceptable
Related Items	General Practitioner First Given Name, General Practitioner Second Given Name, General Practitioner Address, General Practitioner Medicare Provider Number
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	GPSurname
Reporting Guide	Report the surname of the patient's general practitioner/local doctor/ local medical officer.

General Practitioner First Given Name

Definition	The first given name of the patient's general practitioner/local doctor/ local medical officer.
Purpose	Collected for administrative purposes.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	2215
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Not applicable
Validations	The first character must be alphabetic. Can be auto-extracted from the patient administration system.
Missing Data	Acceptable
Related Items	General Practitioner Surname, General Practitioner Second Given Name, General Practitioner Address, General Practitioner Medicare Provider Number
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	GPFirstName
Reporting Guide	Report the first given name of the patient's general practitioner/local doctor/local medical officer if available.

General Practitioner Second Given Name

Definition	The second given name or second initial of the patient's general practitioner/local doctor/local medical officer.
Purpose	Collected for administrative purposes.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	2216
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Not applicable
Validations	The first character must be alphabetic. Can be auto-extracted from the patient administration system.
Missing Data	Acceptable
Related Items	General Practitioner Surname, General Practitioner First Given Name, General Practitioner Address, General Practitioner Medicare Provider Number
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	GPSecondName
Reporting Guide	Report the second given name or second initial of the patient's general practitioner/local doctor/local medical officer if available.

General Practitioner Address

Definition	The address of the patient's general practitioner/local doctor/local medical officer.
Purpose	Collected for administrative purposes.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	2220
Data Type	String
Format	X(75)
Field Size	Maximum 75
Code Set	Not applicable
Validations	Can be auto-extracted from the patient administration system.
Missing Data	Acceptable
Related Items	General Practitioner Surname, General Practitioner First Given Name, General Practitioner Second Given Name, General Practitioner Medicare Provider Number
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	GPAddress

Reporting Guide	Report the address of the patient's general practitioner/local doctor/local medical officer if available. Include the name of the medical centre or practice if known/applicable. Report the street number, street name, suburb and postcode separated by a space.

General Practitioner Medicare Provider Number

Definition	The Medicare Provider Number is the provider number as issued by Medicare which uniquely identifies the doctor and the location from which the service is delivered.
Purpose	Collected for administrative purposes.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	2225
Data Type	String
Format	X(8)
Field Size	8
Code Set	Not applicable
Validations	Nil
Missing Data	Acceptable
Related Items	General Practitioner Surname, General Practitioner First Given Name, General Practitioner Second Given Name, General Practitioner Address
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	GPMediProvidNo
Reporting Guide	Report the Medicare provider number of the patient's general practitioner/local doctor/local medical officer if available.

Name of Person Completing the Registration

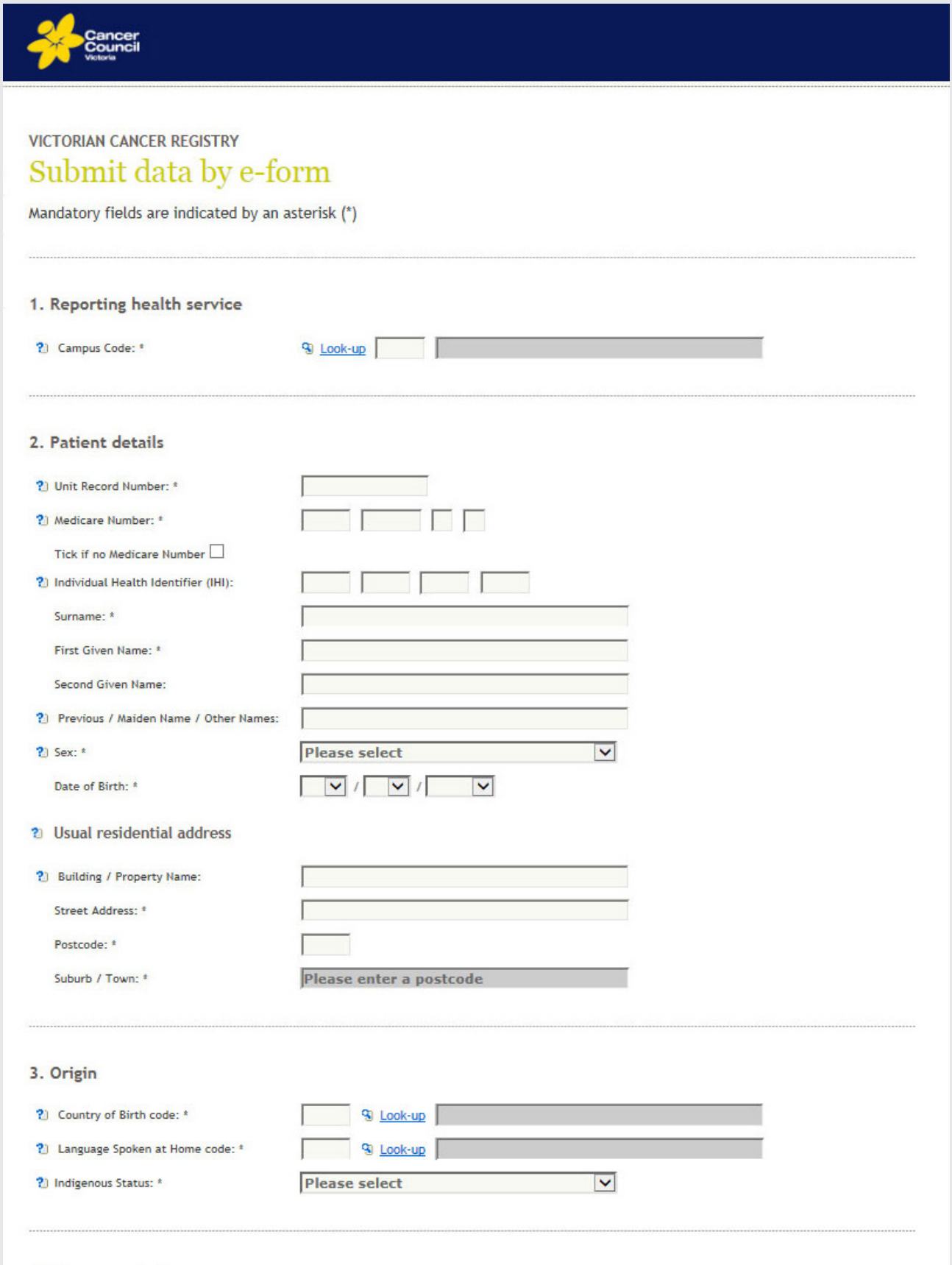
Definition	The full name of the person completing the cancer registration.
Purpose	Collected for administrative purposes.
Reporting Obligation	Mandatory
ASCII Field/Line No.	2900
Data Type	String
Format	X(50)
Field Size	Maximum 50
Code Set	Not applicable
Validations	System-derived
Missing Data	Not acceptable
Related Items	Date of Registration
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	RegName

Reporting Guide	Report the given name and surname of the person completing the cancer registration.

Date of Registration

Definition	The date the cancer registration is completed.
Purpose	To differentiate between similar cancer notifications sent at a later date which may contain further information.
Reporting Obligation	Mandatory
ASCII Field/Line No.	2910
Data Type	Date
Format	DDMMYYYY
Field Size	8
Code Set	Valid date
Validations	Default to current system date
Missing Data	Not acceptable
Related Items	Name of Person Completing the Registration
Definition Source	VCR
Code Set Source	Not applicable
XML Tag	RegDate
Reporting Guide	Report the date of completing the cancer registration.

Appendix 1: E-form webpage screenshot



Cancer Council Victoria

VICTORIAN CANCER REGISTRY

Submit data by e-form

Mandatory fields are indicated by an asterisk (*)

1. Reporting health service

Campus Code: * Look-up

2. Patient details

Unit Record Number: *

Medicare Number: *

Tick if no Medicare Number

Individual Health Identifier (IHI):

Surname: *

First Given Name: *

Second Given Name:

Previous / Maiden Name / Other Names:

Sex: * Please select

Date of Birth: * / /

Usual residential address

Building / Property Name:

Street Address: *

Postcode: *

Suburb / Town: * Please enter a postcode

3. Origin

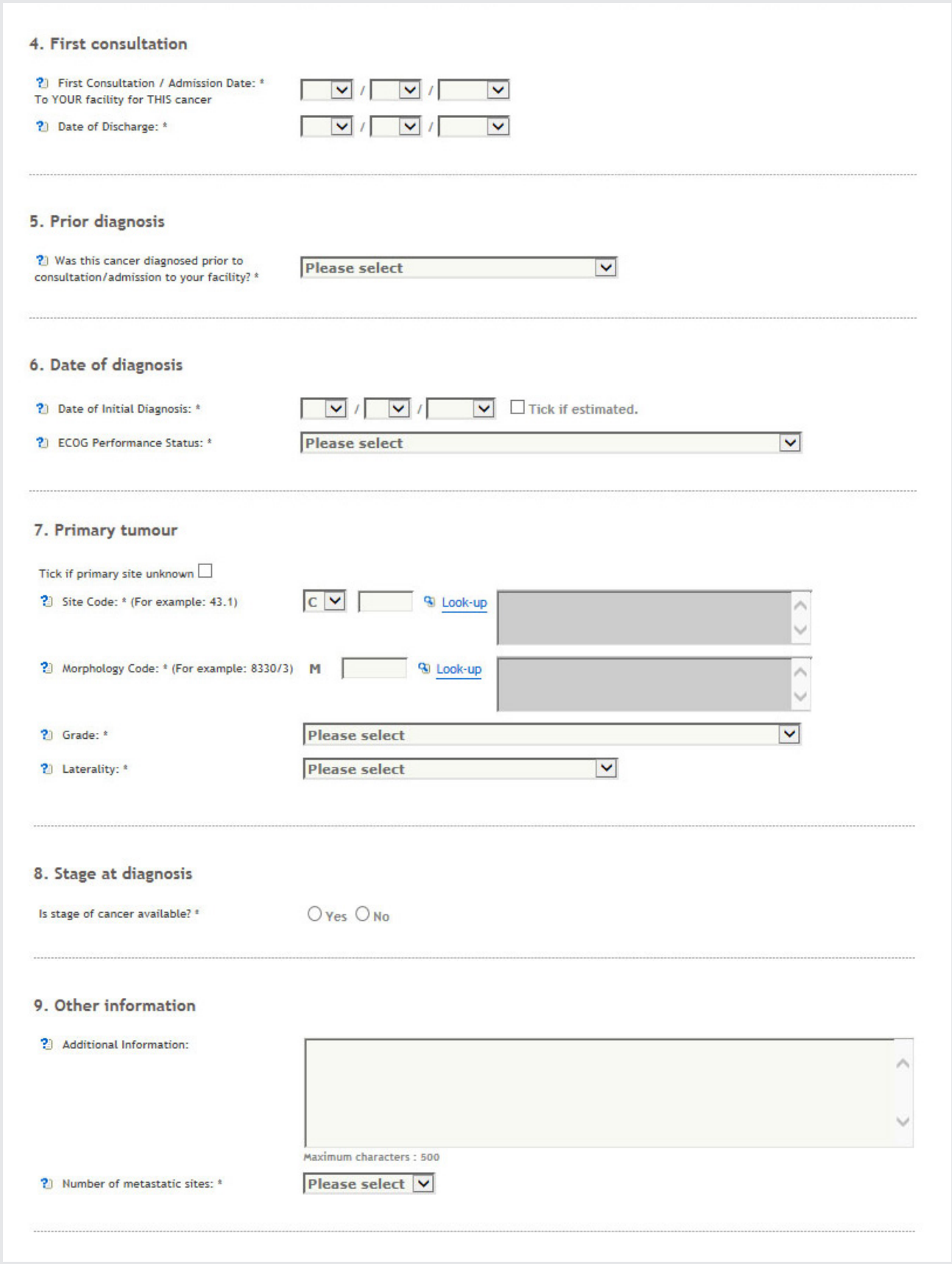
Country of Birth code: * Look-up

Language Spoken at Home code: * Look-up

Indigenous Status: * Please select

(*continued*)

(*E-form webpage screenshot continued*)



4. First consultation

First Consultation / Admission Date: * To YOUR facility for THIS cancer

Date of Discharge: *

5. Prior diagnosis

Was this cancer diagnosed prior to consultation/admission to your facility? *

Please select

6. Date of diagnosis

Date of Initial Diagnosis: *

Tick if estimated.

ECOG Performance Status: *

Please select

7. Primary tumour

Tick if primary site unknown

Site Code: * (For example: 43.1)

C

Look-up

Morphology Code: * (For example: 8330/3)

M

Look-up

Grade: *

Please select

Laterality: *

Please select

8. Stage at diagnosis

Is stage of cancer available? *

Yes No

9. Other information

Additional Information:

Maximum characters : 500

Number of metastatic sites: *

Please select

(*continued*)

(*E-form webpage screenshot continued*)

10. Investigations

Tick all investigations relevant to the diagnosis of this cancer: *

- ☐ Histology of primary tumour
- ☐ Histology of metastasis
- ☐ Cytology/Haematology
- ☐ Exploratory surgery
- ☐ Endoscopy
- ☐ Imaging
- ☐ Biochemistry/Immunology
- ☐ Clinical only
- ☐ Other

11. Treating doctor

Surname: *

First Given Name: *

Second Given Name / Initial:

Medicare Provider Number:

Address/Practice Name:

Suburb / Town:

Postcode:

12. General practitioner / local doctor

Is the local doctor the same as the treating doctor above? ○ Yes ○ No

Surname:

First Given Name:

Second Given Name / Initial:

Medicare Provider Number:

Address/Practice Name:

Suburb / Town:

Postcode:

Options

Save for later [?] Submit e-form [?] Print

Appendix 2: XML File Specifications

Sections of the File

The XML extract file contains the cancer registration records for a hospital or health service.

The file is organised into three sections: XML Declaration, Submission Header and the Cancer Registration Record. Details of the file sections and structure of the file are displayed below.

Section	XML Tag	Description
XML Declaration		This is the first line in the file. The XML declaration value is: <?xml version="1.0" encoding="UTF-8"?>
Submission Header	<CancerExtract>	The Submission Header is a wrapper which encapsulates all the data in the file. The Submission Header has an opening XML tag for the start of the file <CancerExtract>, and a closing XML tag for the end of the file </CancerExtract>. The Cancer Registration extract file may contain one or more Cancer Registration Records.
Cancer Registration Record	<CancerRegRec>	Each Cancer Registration Record has an opening XML tag <CancerRegRec>, and a closing XML tag </CancerRegRec>. The Cancer Registration Record contains the Cancer Registration Record data items. See Structure of the Cancer Registration Record.

Structure of the File

XML declaration
<CancerExtract>
<CancerRegRec>
see Structure of the Cancer Registration Record
</CancerRegRec>

Repeat <CancerRegRec> for each cancer registration.

</CancerExtract>

Structure of the Cancer Registration Record

The Cancer Registration Record is divided into two main groups, Demographic and Tumour.

The two main groups are further divided into subgroups and within the subgroups are the data items.

Each group and subgroup must only occur once within a Cancer Registration Record.

Below are the groups, subgroups, data items and corresponding XML tags in the Cancer Registration Record.

Group	Subgroup	Data Item Name	XML Tag
			<CancerRegRec>
Demographic	PatientName	Patient Surname	<PatSurname>
		Patient First Given Name	<PatFirstName>
		Patient Second Given Name	<PatSecondName>
		Previous/Maiden/Other Names	<PatOtherName>
	PatientDetail	Date of Birth	<DOB>
		Sex	<Sex>
		Medicare Number	<MedicareNo>
		Individual Healthcare Identifier	<IHI>
		Country of Birth	<COB>
		Language Spoken at Home	<Language>
		Indigenous Status	<IndigStatus>
	PatientAddress	Building/Property Name	<PropertyName>
		Street Address	<StreetAddr>
		Suburb	<Suburb>
		Postcode	<Postcode>

(*continued*)

(*Structure of the Cancer Registration Record continued*)

Group	Subgroup	Data Item Name	XML Tag
Tumour	TreatingDoctor	Treating Doctor Surname	<TDSurname>
		Treating Doctor First Given Name	<TDFirstName>
		Treating Doctor Second Given Name	<TDSecondName>
		Treating Doctor Address	<TDAddress>
		Treating Doctor Medicare Provider Number	<TDMediProvidNo>
	HospitalEpisode	Hospital Name	<HospitalName>
		Hospital Campus Code	<CampusCode>
		Unit Record Number	<URN>
		Date of Admission	<AdmissionDate>
		Date of Discharge	<DischargeDate>
	TumourDetail	Date of Diagnosis of Primary Cancer	<DiagnosisDate>
		Estimated Date Flag	<EstDateFlag>
		Cancer Diagnosed Prior to Admission Flag	<PriorDiagFlag>
		Where Previously Diagnosed	<WhereDiagnosed>
		Primary Site	<PrimarySite>
		Laterality of Primary Tumour	<Laterality>
		Morphology	<Morph>
		Grade	<Grade>
		Investigations	<Investigations>
		ECOG Performance Status	<ECOG>
		Metastatic Site	<MetSite>
		Additional Information	<AdditInfo>

(*continued*)

(*Structure of the Cancer Registration Record continued*)

Group	Subgroup	Data Item Name	XML Tag
Tumour (*continued*)	Stage	Stage	<Stage>
		Staging System	<StagingSystem>
		TNM Stage - T code	<TNM-T>
		TNM Stage - N code	<TNM-N>
		TNM Stage - M code	<TNM-M>
	GP	General Practitioner Surname	<GPSurname>
		General Practitioner First Given Name	<GPFirstName>
		General Practitioner Second Given Name	<GPSecondName>
		General Practitioner Address	<GPAddress>
		General Practitioner Medicare Provider Number	<GPMediProvidNo>
	RegDetail	Name of Person Completing the Registration	<RegName>
		Date of Registration	<RegDate>
			</CancerRegRec>

XML Data Specifications

On the following page are the XML field specifications (XML Data Summary Table) for the 49 prescribed data items.

The XML schema can be provided to software vendors upon request.

XML Field Legend

Obligation:

M = Mandatory
M/A = Mandatory if data available/applicable

Type:

X = String
A = Alphabetic
N = Numeric
D = Date

XML Data Summary Table

XML Tag	Data Item	Obligation	Type	Max. Field Length
<CancerRegRec>	*{start of record}*			0
<PatSurname>	Patient Surname	M	X	30
<PatFirstName>	Patient First Given Name	M	X	30
<PatSecondName>	Patient Second Given Name	M/A	X	30
<PatOtherName>	Previous/Maiden/Other Names	M/A	X	50
<DOB>	Date of Birth	M	D	8
<Sex>	Sex	M	N	1
<MedicareNo>	Medicare Number	M/A	N	11
<IHI>	Individual Healthcare Identifier	M/A	N	16
<COB>	Country of Birth	M	N	4
<Language>	Language Spoken at Home	M	N	4
<IndigStatus>	Indigenous Status	M	N	1
<PropertyName>	Building/Property Name	M/A	X	50
<StreetAddr>	Street Address	M	X	50
<Suburb>	Suburb	M	X	30
<Postcode>	Postcode	M	N	4
<TDSurname>	Treating Doctor Surname	M	X	30
<TDFirstName>	Treating Doctor First Given Name	M	X	30
<TDSecondName>	Treating Doctor Second Given Name	M/A	X	20
<TDAddress>	Treating Doctor Address	M/A	X	75
<TDMediProvidNo>	Treating Doctor Medicare Provider Number	M/A	X	8
<HospitalName>	Hospital Name	M	X	50
<CampusCode>	Hospital Campus Code	M	N	4
<URN>	Unit Record Number	M	X	15
<AdmissionDate>	Date of Admission	M	D	8
<DischargeDate>	Date of Discharge	M	D	8

(*continued*)

(XML Data Summary Table continued)

XML Tag	Data Item	Obligation	Type	Max. Field Length
<DiagnosisDate>	Date of Diagnosis of Primary Cancer	M	D	8
<EstDateFlag>	Estimated Date Flag	M	N	1
<PriorDiagFlag>	Cancer Diagnosed Prior to Admission Flag	M	A	1
<WhereDiagnosed>	Where Previously Diagnosed	M/A	X	75
<PrimarySite>	Primary Site	M	X	5
<Laterality>	Laterality of Primary Tumour	M	N	1
<Morph>	Morphology	M	N	5
<Grade>	Grade	M	N	1
<Investigations>	Investigations	M	X	15
<ECOG>	ECOG Performance Status	M	N	1
<MetSite>	Metastatic Site	M/A	X	75
<AdditInfo>	Additional Information	M/A	X	225
<Stage>	Stage	M	X	2
<StagingSystem>	Staging System	M	N	2
<TNM-T>	TNM Stage – T code	M/A	X	5
<TNM-N>	TNM Stage – N code	M/A	X	5
<TNM-M>	TNM Stage – M code	M/A	X	5
<GPSurname>	General Practitioner Surname	M/A	X	30
<GPFirstName>	General Practitioner First Given Name	M/A	X	30
<GPSecondName>	General Practitioner Second Given Name	M/A	X	30
<GPAddress>	General Practitioner Address	M/A	X	75
<GPMediProvidNo>	General Practitioner Medicare Provider Number	M/A	X	8
<RegName>	Name of Person Completing the Registration	M	X	50
<RegDate>	Date of Registration	M	D	8
</CancerRegRec>	*{end of record}*			0

Appendix 3: Sample Hospital Cancer Registration Extract Record (ASCII text file)

The following sample cancer registration record (fictional person and hospital) is to illustrate the standard format for the ASCII text file when viewed using a text viewer such as Notepad. Each and every line, without exception, is associated with a field line number. Where data is not collected for some fields, it is preferable to include the field line number even though the field will be blank (for example, line 1060).

1000
1010 SMITH
1020 JOHN
1030 JAMES
1040 24071945
1050 1
1055 30672891042
1056 8003601204567891
1060
1070 4
1100 PINEWOOD LODGE NURSING HOME
1110 UNIT 1 25 MAIN ST
1120 RICHMOND
1130 3121
1140 1101
1150 1201
1210 JONES
1215 TOM
1216 M
1220 SUITE 2 SPECIALIST CENTRE 23 SOUTH ST MELBOURNE 3000
1225 1234567A
1230 ALFRED HOSPITAL
1235 1010
1240 123456
1260 02062018
1270 25052015
1271 0
1280 Y
1285 Royal Melbourne Hospital Path biopsy no. 12345 25/05/2015
1290 04062018
1320 C61
1325 8
1340 C780 C795
1360 81403
1365 3
1370 8 7 3
1372 1
1373 Gleason 3+4
1391 3B
1392 12
1393 p3b
1394 p1
1395 0
2210 MCNALLY
2215 JOHN
2216 M
2220 BURWOOD CLINIC 400 BURWOOD HWY BURWOOD 3125
2225 6543219A
2900 Katy Coder
2910 01072018
2999
1000 (Start of next record)

Document Amendment History

Date	Section	Description
May 2008	Notifiable Cancers and Cancer Act Reporting Regulations	These sections have been removed from this document and are now included in the Victorian Cancer Registry -Guide to Reportable Cancers.
December 2008	1.6.3 File specifications	Field 1271 Estimated Date Flag - Valid code for "date not estimated" changed from null to zero. New Field 1335 Evidence of Metastatic Disease at Diagnosis added to flag the presence of metastases at time of reporting. Field 1340 ICD-10AM Metastatic Site Codes - Range of valid metastatic site codes included in Comments section.
February 2009	1.6.3 File specifications	Field 1335 Evidence of Metastatic Disease at Diagnosis – further clarification required, renamed to: Field 1335 Evidence of Metastatic Disease **at this Admission** The following fields are no longer required to be reported and have been removed from the specs: • Field 1375 Date of diagnosis of first tumour recurrence • Field 1376 Site of first tumour recurrence • Field 1710 Autopsy Performed The following fields have been reviewed and should contain codes as per the current **DHS-VAED reporting guidelines:** • Field 1070 Indigenous Status • Field 1140 Country of Birth (SACC)
December 2011 (not released)	1.6.3 File specifications	Field line 1365 Histological Grade/Differentiation or Cell type for leukaemias – deleted obsolete options from Comments section. Modified various field properties from O 'Optional' to M* 'If data available it should be reported'.
	2. Overview of reporting requirements	Deleted section titled 'Overview of reporting Requirements'. This information has been moved to the revised VCR Guide to Reportable Cancers document.

(*continued*)

(*Document Amendment History continued*)

Date	Section	Description
October 2012	1.6.3 File specifications	File specifications have been moved from section 1.6.3 to Appendix 1. New Field line 1056 Individual Health Identifier added in response to the Cancer (Reporting) Regulations 2012. New Field line 1150 Language Spoken at Home added in response to the Cancer (Reporting) Regulations 2012. New Field line 1372 ECOG Performance Status added in response to the Cancer (Reporting) Regulations 2012. New Field line 1373 Additional Information added in response to the Cancer (Reporting) Regulations 2012. New Field line 1374 Degree of Spread added in response to the Cancer (Reporting) Regulations 2012.
	1.6.4 Sample report	Sample report has been moved from section 1.6.4 to Appendix 2. Sample report updated to reflect new field lines.
	3. Document amendment history	Document amendment history has now been moved from Section 3 to Appendix 3. General revision of document.
October 2013		General revision of document.
January 2014		New address and contact details updated

(*continued*)

(*Document Amendment History continued*)

Date	Section	Description
December 2015	Appendix 1 – Hospital File Specifications	New fields added in accordance with the *Improving Cancer Outcomes (Diagnosis Reporting) Regulations 2015 (Vic)*: • Field 1225 Treating Doctor Medicare Provider Number • Field 1390 Stage of Cancer Flag • Field 1391 Stage of Cancer at Diagnosis • Field 1392 Cancer Staging System • Field 2225 General Practitioner Medicare Provider Number Removed field 1374 Degree of Spread. This field is no longer required to be reported and has been replaced by Field 1391 Stage of Cancer at Diagnosis, in accordance with the *Improving Cancer Outcomes (Diagnosis Reporting) Regulations 2015 (Vic)* New Field 1100 Building/Property Name added to enhance reporting of patient address Decreased the maximum field length for all date fields from 10 to 8 characters
	Appendix 2 – Radiotherapy file specifications	New file specifications for radiotherapy services in accordance with the *Improving Cancer Outcomes (Diagnosis Reporting) Regulations 2015 (Vic)*
	Appendix 1A - Additional fields required for BreastScreen only	Removed in accordance with the *Improving Cancer Outcomes (Diagnosis Reporting) Regulations 2015 (Vic)*
December 2017	Whole document	General revision of document
		Removal of any reference to radiotherapy.
		Inclusion of Addendum – Cancer Stage at Diagnosis Lookup Table into specifications.
		Reformat of specifications to one page per data item.
		Increased reporting guide information.
		Increased validations for some data items.
		Inclusions of XML file format instructions.

(*continued*)

(*Document Amendment History continued*)

Date	Section	Description
	Relabelling of data items	[Field 1010] Surname changed to Patient Surname
		[Field 1020] First Given Name changed to Patient First Given Name
		[Field 1030] Second Given Name changed to Patient Second Given Name
		[Field 1056] Individual Health Identifier changed to Individual Healthcare Identifier
		[Field 1060] Previous/Maiden Name changed to Previous/Maiden/ Other Name(s)
		[Field 1230] Hospital or Hospital Campus Name changed to Hospital Name
		[Field 1260] Admission Date or Consultation Date changed to Date of Admission
		[Field 1270] Date of Diagnosis changed to Date of Diagnosis of Primary Cancer
		[Field 1280] Cancer Diagnosed Prior to Admission/Consultation changed to Cancer Diagnosed Prior to Admission Flag
		[Field 1285] If Yes, Where Diagnosed changed to Where Previously Diagnosed
		[Field 1320] ICD-10-AM Primary Site Code changed to Primary Site
		[Field 1340] ICD-10-AM Metastatic Site Code(s) changed to Metastatic Site
		[Field 1360] ICD-10-AM Morphology Code changed to Morphology
		[Field 1365] Histological Grade/Differentiation changed to Grade
		[Field 1370] Investigations relevant to the Diagnosis changed to Investigations
		[Field 1391] Stage of Cancer at Diagnosis changed to Stage
		[Field 2216] General Practitioner Second Given Name or Initial changed to General Practitioner Second Given Name
		[Field 2900] Name of Person Completing the Cancer Registration changed to Name of Person Completing the Registration
		[Field 2910] Date Registration Completed changed to Date of Registration

(*continued*)

(*Document Amendment History continued*)

Date	Section	Description
	Removal of data items	[Field 1330] Primary Site Text Description
		[Field 1335] Evidence of Metastatic Disease
		[Field 1345] Metastatic Site Text Description
		[Field 1371] Other Basis of Diagnosis
		[Field 1390] Stage of Cancer Flag
	Update of code set	[Field 1050] Sex – removal of word Intersex (3), change of Not Stated (9) to Other (4)
		[Field 1365] Histological Grade/Differentiation to Grade – update of descriptors
		[Field 1372] ECOG Performance Status – removal of status 5
		[Field 1391] Stage – addition of Not applicable/Not available/ Unknown/Other (9).
	Change of field size	[Field 1360] Morphology field size decreased from 25 to 5
	New data items	[Field 1393] TNM Stage – T code
		[Field 1394] TNM Stage – N code
		[Field 1395] TNM Stage – M code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